Top 10 Things to do to Prepare for MIPS

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Since the MACRA Final Rule came out, healthcare providers who participate in Medicare Part B are trying to figure out how to maximize their incentives or at least avoid penalties under the new Quality Payment Program that includes MIPS. The clock is already ticking since performance in 2017 impacts payments in 2019. Where should you start? Here is our list of the top 10 things you should do now to maximize your performance in 2017 and beyond.

Top 10 Things to do to Prepare for MIPS

1. Accept that MACRA isn't getting repealed
2. Calculate how much money is at risk
3. Assess your readiness and plan to close gaps
4. Establish program governance & management
5. Collaborate with your vendors
6. Engage & prepare your providers
7. Use analytics to monitor and improve performance
8. Prepare for Cost measures in 2018 & beyond
9. Plan how to use MIPS to prepare for (or expand) value-based care
10. Educate & communicate

#1. Accept that MACRA isn't getting repealed.

While there is talk that the Accountable Care Act (aka Obamacare) may eventually get repealed, no one is talking about repealing MACRA. In an increasingly partisan congress, MACRA was one of the few pieces of legislation that got *bipartisan* support. Both parties recognize that healthcare costs need to be contained and moving toward value-based care is how they plan to accomplish it.

#2. Calculate how much money is at risk.

Your financial risk or reward is based on your Medicare Part B allowable charges. Any physician, PA, NP, CNS or CRNA who bills ≥ $30K AND ≥ 100 patients under Medicare Part B is eligible. The amount of money at risk for 2017 is:

$$\left[-4\% \times \text{Annual Part B Payments}\right] \text{ to } \left[+4\% \times \text{Annual Part B Payments}\right]$$

The amount increases to +/-5% in 2018, +/-7% in 2019, and +/-9% in 2020.

#3. Assess your readiness and plan to close gaps

Review your current Meaningful Use and PQRS data to get a baseline view of your readiness for the Quality and Advancing Care Information (ACI) tracks. Review on-

going performance improvement initiatives to see if they qualify as Improvement Activities (IA). Use this review to estimate your Composite Performance Score (CPS), identify gaps in key areas (people, process, data, and technology), and develop a plan to close those gaps. Key question to examine include:
Quality. Do you already submit 6 or more Quality Measures? Are these Quality Measures included in the Quality Category under MIPS? Do they have benchmarks associated with your planned method of submission? How you are currently doing versus the benchmarks from 2016 for each quality measure?

ACI. There are no exclusions for the base requirements of ACI. Can you validate you can complete the process measure for HIE at least once (previously Transitions of Care)? Do you e-Prescribe? What ACI measures are you best positioned to focus on for performance objectives?

IA. Are you currently part of a Patient Centered Medical Home (PCMH) or do you have existing activities that are on or similar to items on the IA list?

#4. Establish program governance and management.

If your organization has multiple practices and specialties, program governance and management will be crucial. Silos plague healthcare and performing well on MIPS will require collaboration across multiple areas: between inpatient and ambulatory, across specialties/practices, with IT (for EHR, HIEs, and registries), with your analytics team/data analysts, between Finance and Clinical Quality. We recommend starting with 3 things: 1) a MIPS or Value-Based Care Steering Committee that includes key leaders from all of these stakeholder groups, 2) a Program Manager to 'herd the cats' and manage overall program performance and risk, and 3) a Practice Manager Collaborative that enables Practice Managers to share information and collaborate on key efforts related to MIPS – like communication plans, provider education, aligning on common tools, etc.

#5. Collaborate with your vendors.

Having a good working relationship with your EHR, registry and other key technology vendors can save you time and effort. Ask your vendor(s) for their MACRA roadmap and how they plan to support your efforts to both meet MIPS requirements now and evolve to participate in advanced payment models (APMs) in the future. They may not have all the answers yet, but it is important that you are comfortable with their timelines and plans for supporting your efforts. Key questions to consider include: Do you have all the technology needed to meet the base requirements for ACI (such as an HIE or HISP)? Do your current systems support the quality measures you plan to submit? How are data for quality measures captured? Is it sustainable/scalable? What submission method and technology will best support your MIPS goals? Can your vendor(s) provide timely, actionable data? What are the costs of any solutions or upgrades you need for both MIPS performance (short-term) and APM participation (long-term)? Will your current vendor(s) be a good partner for future Value-Based Care initiatives like APM participation?

#6. Engage and prepare your providers.

Providers are crucial partners to performing well in MIPS. You can't move the needle on Quality, Advancing Care Information, or Cost measures without them. Therefore, you need their buy-in and engagement. Start with communication and education. We've found peer-to-peer communication is most effective so recruit physician champions to help. Also, *listen to providers* and collaborate with them. Get their input on which quality measures and IAs to select and workflow and EHR changes needed to facilitate performance improvement. Providing actionable analytics in the form of provider dashboards and reports can help build engagement. Give them timely, actionable information they can use to improve their performance on quality and other outcome measures. As you move toward value-based care and risk-based contracts, building quality and other outcomes into compensation plans will be an important means of getting provider engagement, too.

#7. Use analytics to monitor and improve CPS performance

In MIPS, CMS will grade you on a bell curve – whether you get a penalty or incentive payment will depend on if you are in the top or bottom compared to other Medicare Part B providers. To make sure you are a top performer, you will need timely, actionable analytics to monitor your performance and intervene when you see trouble spots. We recommend an administrator/practice manager view that shows performance across all of your practices, specialties, and providers. This way you can identify key segments or individuals who need help. Also, you'll need the provider dashboards we mentioned above to enable providers to monitor and improve their individual performance.

#8. Prepare for Cost measures in 2018 & beyond

While Cost isn't included in your 2017 CPS score, it will increase to 10% of your 2018 score and 30% in 2019. 2017 is your year to get ready. To improve performance on cost, you need a holistic and proactive approach to measure and improve cost of care. CMS will use the following two measures to calculate your cost performance for MIPS: 1) Per Capita Costs for All Attributed Beneficiaries and, 2) Medicare Spending per Beneficiary. They may add condition-based cost measures to the Cost component in 2019 and beyond. Here are some steps you can take to prepare for this:

1. Review your performance on your most recent CMS Quality and Resource Use Reports (QRUR). This report provides your baseline performance on the above risk adjusted cost metrics. Your percentile rank on this report indicates where you currently stand on the bell curve for cost. If you are performing poorly on cost now, you need to develop a strategy for how to improve your performance before the 2018 performance year starts.
2. If you don't have them in place already, implement the systems, processes, and roles needed to monitor an improve performance on cost and utilization. Many people think this means getting and analyzing their post-adjudicated claims from CMS, which is good. However, post-adjudicated claims usually have a substantial time lag before they are available (3+ months), so it is not as

useful for proactively improving cost and utilization. Therefore, also consider a solution that uses your charge data (pre-adjudicated claims) to provide directionally correct and much more timely cost and utilization data. Using this proxy approach to analyzing episodic cost and utilization provides much more timely data to effectively engage providers and patients in proactive clinical improvements.

#9. Plan how to use MIPS to prepare for (or expand) value-based care

MIPS is foundational to prepare for value based care and APMs. The four tracks of MIPS – quality, cost, improvement activities, and advancing care information – encourage you to setup systematic processes and programs that improve quality of care and lower costs. These processes and programs need to establish data liquidity, cost containment and improvement programs that provide the foundation needed to successfully participate in one or more APM models. Risk bearing contracts (either downside or upside) require a vision of value and systematic support for quantifying and improving clinical and cost outcomes. Use MIPS to build the strong foundation you will need to demonstrate your effectiveness and the value of care you deliver when you begin participating in an APM.

#10. Educate & communicate

Educate, educate, educate…whether it's on the regulatory requirements or how to capture the data in the system, develop and execute a communication plan to support your efforts to perform well in MIPS in the near-term and, just as importantly, to prepare you for an APM in the long term. Educate your key stakeholders - not only executives and clinicians but also Practice Managers, EHR & HIE teams, the BI team/Data Analysts and others involved in executing your MIPS plans. Examine your current and new channels of communication to find the optimal channel(s) for delivering key messages. Also, create a calendar of key messages that starts with basic education, but quickly moves to a call to action for each of you key stakeholder groups.

FINAL THOUGHTS

Expect the regulations to continue to change, but recognize that value based payment models are here to stay. Whether under Medicare, Medicaid, or a Private Payer, one day a majority of healthcare will be reimbursed in the value based manner outlined in MACRA's Quality Payment Program MIPS and APM tracks. Instead of 'checking the boxes' for MIPS, use it as a means to develop the foundation you need for value based care.

To continue the conversation on preparing for MIPS contact Coleman Smith (csmith@himformatics.com).